SECTION 2

OCCUPATIONAL THERAPY SERVICES

By Independent Occupational Therapists, including Group Practices, Not in Rehabilitation Centers

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1 GENERAL POLICY

Occupational therapy as described in this SECTION 2 is a benefit of the Utah Medicaid Program. All occupational therapy services must be performed by an occupational therapist or, effective January 1, 2002, by an occupational therapy assistant according to the provision of Utah State Code 58-42a-306 and as defined in Chapter 1 - 3, Definitions.

The policy in this Section applies only to independent occupational therapists, including group practices. If the occupational therapist is associated with a rehabilitation center with physical therapists and which uses a treatment planning team or committee, refer to SECTION 2 titled Physical Therapy and Occupational Therapy Services in Rehabilitation Centers.

Occupational therapy evaluation and treatment are authorized under the authority of the 42 CFR in Section 410.59 and Utah Administrative Code, Utah Department of Health Rule R414-20.

1 - 1 Purpose

The purpose of the occupational therapy program is to increase the functioning ability of a Medicaid recipient who has a handicap, whether the handicap is temporary or permanent, in order to increase independent living.

The rehabilitation goals must include evaluation of the potential of each individual patient, the factual statement of the level of functions present, the identification of the goal that may reasonably be achieved, and the predetermined space of time and concentration of services that would achieve the goal.

The Medicaid program is designed to provide services within financial limitations. A desired level of function must be balanced with an achievable level of function within a defined length of time. The objectives of the program are to provide a scope of service, supplementary information, limitations, and instructions concerning prior authorizations, billing, and utilization which clearly direct the therapist to accomplish the goals he or she and the patient have jointly identified.

The goal of the occupational therapist is to improve the ability of the patient, through the rehabilitative process, to function at a maximum level.

1 - 2 Occupational Therapy in Rehabilitation Centers

Occupational therapists associated with a rehabilitation center utilizing a treatment planning team or committee MUST FOLLOW the combined physical therapy/occupational therapy program and billing codes described in SECTION 2 titled Physical Therapy and Occupational Therapy Services in Rehabilitation Centers. The facility bills for these services. This program merges occupational therapy with the physical therapy program and follows the Medicaid physical therapy guidelines and operations.

1 - 3 Objectives of Occupational Therapy

The provider of an occupational therapy program must execute a therapeutic intervention that includes:

1. A clinically sound estimate of the potential level of function actually achievable;

2. Interventions designed to restore the client performances that have been lost to accident, disease, or birth defect to the level reasonable possible;

3. The eventual termination of active intervention and the transfer of the responsibility for identified procedures to family, guardian, or other care-givers which do not require the professional skills of an occupational therapist;

4. A resulting increased level of adaptation, independence, or participation in every day life activities for the patient.

1 - 4 Definitions

Occupational therapy is therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Occupational therapy means the treatment of a human being by the use of therapeutic exercise ADL activities, patient education, family training, home environment evaluation, equipment measurement and fitting or other modalities approved by the American Association of Occupational Therapists.

Occupational therapist means a person who practices occupational therapy.

Qualified occupational therapist means a therapist who meets three conditions:

a. They must be a graduate of a program of occupational therapy approved by both the Council on Medical Education of the American Medical Association and the Accreditation Council for Occupational Therapy (ACOTE), or its equivalents.
b. They must be licensed by the State of Utah to practice Occupational Therapy.
c. They must be enrolled as a provider for the Utah Medicaid Program.

Occupational therapy assistant means an assistant that is qualified as described in 58-42a-302(2) and may provide services under the supervision of a qualified occupational therapist according to the supervision provisions of 58-42a-306. However, all billing must be by the supervising occupational therapist.

Rehabilitation means the process of treatment that leads the disabled individual to attainment of maximum function. (Taber's Cyclopedic Medical Dictionary)

Rehabilitation Services means the delivery of rehabilitative medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state law, for maximum reduction of physical or mental disability and restoration of a Medicaid recipient to his or her best possible functional level.

1 - 5 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed health care plan must receive all health care services through that plan. Refer to SECTION 1, GENERAL INFORMATION, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, GENERAL INFORMATION, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this Section of the Utah Medicaid Provider Manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of Managed Care providers with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual or available by contacting Medicaid Customer Service. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the client must use is available to providers, a "fee-for-service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 6 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 7 Residents of Intermediate Care Facilities for Mentally Retarded (ICF/MR)

An ICF/MR facility must provide and pay for occupational therapy when a client resides in the facility and requires occupational therapy as part of the plan of care. Reference: 42 CFR 442.486

Evaluation and therapy are components of the treatment plan and are the responsibility of the facility.

2 COVERED SERVICES FOR ADULTS

1. Occupational therapy is limited to conditions resulting from traumatic brain injury, spinal cord injury, hand injury, congenital anomalies or developmental disabilities causing neurodevelopmental deficits, or CVA (treatment must begin within 90 days of the incident). Other conditions are not covered.

2. Clients must be referred by a doctor of medicine or other practitioner of the healing arts within the scope of his or her practice.

3. Evaluations are limited to one evaluation annually. Written prior authorization is required beyond this limit.

4. The service must be of a level of complexity and sophistication, or the condition of the client must be such that services required can be safely and effectively performed only by a qualified occupational therapist.

5. Services must be professionally appropriate according to standards in the field, utilizing professionally appropriate methods and materials, in a professionally appropriate environment.

6. Provision of service is with the expectation that the condition under treatment will improve in a reasonable and predictable time.

7. Occupational therapy treatments are limited to one per day.

2 - 1 Occupational Therapy Procedures

The therapy procedure code includes various occupational therapy modalities. There are no specific procedure codes in the Medicaid program for specific therapies. The therapist may bill the necessary modality under one procedure code. (T1015 with a GO modifier. Refer to Chapter 5, Procedure Codes.)

2 - 2 Limitations

1. Occupational therapy is limited to conditions resulting from traumatic brain injury, spinal cord injury, hand injury, congenital anomalies or developmental disabilities causing neurodevelopmental deficits, or CVA (treatment must begin within 90 days of the incident). Other conditions are not covered.

2. All services after the first twenty visits, which includes the evaluation, require prior authorization.

2 - 3 Non-Covered Services

The following services are not covered:

1. Treatment of conditions other than one related to traumatic brain injury, spinal cord injury, hand injury, neurodevelopment deficits, and cerebral vascular accident (CVA).

2. Treatment for only social or educational needs.

3. Treatment for clients who have stable chronic conditions which cannot benefit from occupational therapy services.

4. Treatment for clients for whom there is not documented potential for improvement.

5. Treatment for clients who have reached maximum potential for improvement.

6. Treatment for clients who have achieved stated goals.

7. Treatment for non-diagnostic, non-therapeutic, routine, repetitive or reinforced procedures.

8. Treatment for cardiovascular accident (CVA) which begins more than 90 days after onset of the CVA.

9. Treatment for residents of ICF/MR.

10. Treatment in excess of one session or service per day.

11. Occupational Therapy is not a benefit through Home Health.

2 - 4 Procedure Codes

The occupational therapy codes in this chapter may be used only by a qualified, independent occupational therapist. If the occupational therapist is associated with a clinic/rehabilitation center, the therapist must refer to SECTION 2 titled, Physical Therapy and Occupational Therapy Services in Rehabilitation Centers.

Occupational therapy procedure codes are as follows:
T1015, Physical therapy evaluation/treatment, per visit, billed with the GO modifier.

The first 20 visits which include the evaluation do not require prior authorization. All additional visits require prior authorization.

These treatments and therapies are understood to be generally in conjunction with physical therapy. If the primary deficit is the upper extremity and physical therapy is **not** used, the number of occupational therapy visits can increase from the averages listed in the charts which follow. This will predominantly occur in cases with traumatic brain injury or CVA.

OCCUPATIONAL THERAPY PROCEDURE CODES

For Services by Independent Occupational Therapists, including Group Practices, Not in Rehabilitation Centers

Instructions for Use of Codes and Explanation of Table Headings

The list which follows describes occupational therapy services covered by Utah's Medicaid program and conditions of coverage. The code and procedures may be used only by occupational therapists NOT associated with a rehabilitation center.

NOTES: Coverage and the prior authorization requirements apply **ONLY** for a Medicaid client (1) assigned to a Primary Care Provider or (2) not enrolled in a managed care plan. The list is updated by Medicaid Information Bulletins until republished in its entirety.

Below is an explanation of each column and codes on the table.

Code	For use only by occupational therapists NOT associated with a rehabilitation center.
Common Diagnosis Or Complications	These are common accompanying diagnoses or complications
Age	"All" means that Medicaid covers the services from birth through any age.
Types of Occupational Therapy	Lists approved therapies covered by Medicaid for the diagnosis.
PA	**PA** means **P**rior **A**uthorization. The entry of **W** means written prior authorization is required by Medicaid.
Comments	All treatment visits require prior authorization. The average number of treatments and duration are stated.

Traumatic Brain Injury

CODES	COMMON DIAGNOSIS OR COMPLICATIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	PA	COMMENTS
T1015	Compression of brain, Cerebral edema, Abnormal involuntary movements, Edema, Feeding difficulties, Dysphagia, Anoxia, Concussion, Decrease range of motion, Decubiti, Perceptual deficit, Spasticity	All	Therapeutic exercise, ADL, supervised hydrotherapy must be related to treatment goals, bracing, home environment evaluation, equipment fitting	**W**	Treatment generally in conjunction with or after Physical Therapy. Average number of treatments: up to 12 annually Duration: 1 - 3 months Acute rehabilitation after initial diagnosis. Emphasis on instruction and teaching to establish independence.

CVA (Stroke)

CODES	COMMON DIAGNOSIS OR COMPLICATIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	PA	COMMENTS
T1015	Hemiplegia, Subarachnoid hemorrhage, Intracerebral hemorrhage, Occlusion and stenosis of pre-cerebral arteries, Occlusion of cerebral artery, Acute cerebrovascular disease, Late effects of cerebrovascular accident.	All	Therapeutic exercise, ADL, evaluation, electrical stimulation, equipment evaluation and fitting, home environment evaluation.	**W**	Treatment generally in conjunction with or after Physical Therapy. Average number of treatments: up to 12 annually Duration: up to 3 months This can result in a life altering insult. Emphasis is placed on physical and mental healing to reintegrate the patient into society and promote independence.

Spinal Cord Injury

CODES	COMMON DIAGNOSIS OR COMPLICATIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	P A	COMMENTS
T1015	Limited range of motion Osteoporosis Decubiti Kidney Disease Malnutrition Bladder and kidney stones	All	Therapeutic exercise, ADL, supervised hydrotherapy must be related to goals, bracing, home environment evaluation, equipment fitting	**W**	Treatment generally in conjunction with or after physical therapy. Average number of treatments: 12 Duration: 3 - 6 months Acute rehabilitation after initial diagnosis. Emphasis on instruction and teaching by the occupational therapist to establish independence.

Hand Injury

CODES	COMMON DIAGNOSIS OR COMPLICATIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	P A	COMMENTS
T1015	Open wound of wrist with tendon involvement Open wound of hand with tendon involvement Open would of fingers with tendon involvement	All	ADL, Therapeutic exercise, splinting, physical agent modalities, home environment evaluation	**W**	Either P.T. or O.T., not both. Average number of treatments: 36 Duration: 1 - 3 months

Neurodevelopmental Deficit

CODES	COMMON DIAGNOSIS OR COMPLICATIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	PA	COMMENTS
T1015	Cerebral palsy Birth Trauma High risk infancy Birth anoxia Developmental delay Spasticity Hypotonia Hypertonia Decrease range of motion Gait Deviation Muscular weakness Joint instability Impaired cognitive function Athetosis Ataxia Gentic Syndromes Chromosome abnormality	All	Neurodevelopmental therapy. Kinesthetic treatment, therapeutic exercise, supervised hydrotherapy must be related to treatment goals, bracing, splinting, ADLs, mobility training, fine motor skills, coordination, adaptive equipment training.	**W**	Treatment in conjunction with or after physical therapy. Average number of treatments: 15 Duration: 12 months Emphasis on achieving independence in gait, ADL's, mobility skills. After each surgical intervention-therapy, needs to be more intensive, then reduced – this is on going. CP therapy prevents further deformity and is chronic in nature.

3 OCCUPATIONAL THERAPY FOR CHILDREN AGE 20 AND YOUNGER

1. Evaluations are limited to one evaluation per calendar year. Written prior authorization is required beyond this limit.

2. The service must be of a level of complexity and sophistication, or the condition of the client must be such that services require the professional skills of an occupational therapist.

3. Services must be professionally appropriate according to standards in the field, utilizing professionally appropriate methods and materials, in a professionally appropriate environment.

4. Provision of service is with the expectation that the condition under treatment will improve in a reasonable and predictable time. Continuation of treatment beyond the maximum rehabilitative potential within specified time will not be approved.

Length of time and number of treatments will be based on the American Occupational Therapy Association guidelines.

A service must be reasonable and medically necessary to the treatment of the client's condition. A service is not reasonable and necessary when the potential for rehabilitation is insignificant in relation to the extent, duration and cost of the occupational therapy. If, at any point in treatment, there is no longer the expectation of significant improvement in a reasonable time, services will no longer be considered reasonable and are not covered.

5. Medicaid will authorize a plan of care based on a six month episode of care. Treatment Plans should be based on an episode of care which is a service delivery model that reflects the amount, frequency, and duration the treatment should be. It is anticipated that the patient will be discharged, or therapy discontinued after the episode of care, as goals and results should have been achieved. Treatment plans should be designed for a specific episode of care lasting up to 6 months. Treatment plan goals should be reasonable and achievable during the episode of care time line and should include the amount, frequency, and duration of the services.

It is not realistic to set goals that will take 24 months to achieve in this model. They should be broken down into smaller increments that are achievable within the six months time frame.

6. Additional services beyond the initial episode of care should be requested as a new episode and accompanied by new, justified, achievable goals.

7. Acute conditions are expected to require rehabilitative services only for one episode of care lasting from one to six months. Chronic conditions are not expected to be rehabilitated in a single episode of care; however, each episode should have goals that are achievable during a six month period.

3 - 1 Limitations

1. All services, after the first twenty visits which includes the evaluation, require prior authorization.

2. The length of time for treatment plans for patients with acute conditions should be planned to complete the resolution of the problem, generally within 2-6 months.

3. Treatment plans for patients with long term, chronic situations should be planned for an episode of care

for six months or less. Additional episodes of care may be authorized in with new goals if medically necessary.

4. Therapy will not be approved when one of the following conditions is met:
   a. Child have achieved functional goals/outcomes. Reaching 95% of the goal is considered a functional accomplishment of the goal.
   b. Child has reached a plateau in progress extending six months or longer, i.e. little or no progress has occurred.
   c. Child/family is unable to participate consistently in treatment because of medical, psychological or social complications.
   d. Child/family is able to follow prescribed occupational therapy program independently or with assistance and does not require the weekly professional skills of a therapist. Maintenance therapy is not covered; however, one therapy session per month to access and retrain the care giver may be allowed.

5. Occupational therapy reimbursement for treatment is limited to one visit per day.

3 - 2 Non-Covered Services

1. Treatment for only social or educational needs.

2. Treatment for clients who have stable, chronic conditions which cannot benefit from occupational therapy services; or for whom there is no documented potential for improvement; or who have reached the maximum potential for improvement.

3. Treatment for clients who have achieved stated goals within the episode of care.

4. Treatment for non-diagnostic, non-therapeutic, routine, repetitive or reinforced procedures; or maintenance therapy to provide routine, repetitive or reinforced procedures of routine care with no progress.

5. Treatment for residents of ICF/MR.

6. Treatment in excess of one session or service per day.

7. Occupational Therapy through Home Health.

8. Occupational therapy if the child/family is able to follow prescribed occupational therapy program independently.

9. Occupational therapy that does not require the skilled services of a licensed occupational therapist or licensed occupational assistant.

10. Services that are not included in the plan of care.

11. Conditions which can reasonably be expected to spontaneously improve (1) with age and development or (2) as the patient resumes normal activity.

3 - 3 Therapy Coding For Children

Delayed Development

CODES	COMMON DIAGNOSIS OR CONDITIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	PA	COMMENTS
T1015 GO	Attention-deficit disorder Hyperactivity disorder Hyperkinesis with developmental delay Mixed development disorder Feeding problems in newborns Lack of coordination Lack of expected normal physiological development Pervasive developmental disorder NOS Feeding disorder of infancy or early childhood Expressive language disorder Mixed receptive-expressive language disorder Developmental coordination disorder Autism Downs Syndrome Feeding difficulty of early childhood Hypotonia Sensory processing disorder	0-20	Neurodevelopmental facilitation techniques, compensatory strategies. Adaptive equipment and training, parent training, splinting, orthotics fitting/training. Visual motor training, positions, environmental modifications. Sensory stimulation, sensorimotor activities. Developmental testing, myofascial release/soft tissue mobilization, Oral-motor facilitation.	**W**	Up to 6 months per episode (Up to 26 visits)

Neurologic Deficit

CODES	COMMON DIAGNOSIS OR CONDITIONS	AGE	TYPE OF OCCUPATIONAL THERAPY	PA	COMMENTS
T1015 GO	Infantile cerebral palsy Dipegia Hemiplegia Audriplegia Monoplegia Infantile hemiplegia Other specified infantile cerebral palsy Infantile cerebral palsy Distonia Muscle Spasticity Subcranial hemorrhage unspecified	0-20	Neurodevelopmental facilitation techniques, compensatory strategies. Adaptive equipment and training, parent training, splinting, orthotics fitting/training. Visual motor training, positions, environmental modifications. Sensory stimulation, sensorimotor activities. Sensory intergrative techniques, wheelchair management, Developmental testing.	**W**	Up to 6 months per episode (Up to 26 visits)

4 PRIOR AUTHORIZATION

One evaluation per treatment course for a specific condition or diagnosis and twenty treatments do not require prior approval. All therapy services beyond the first twenty visits require prior approval before the services begin. For general information about the prior authorization process, refer to SECTION 1, GENERAL INFORMATION of this Provider Manual, Chapter 9, Prior Authorization Process.

1. The request for prior approval for treatment should include a copy of the plan of treatment for the client or a document which includes:

a. The diagnosis, and the severity of the condition;
b. the prognosis for progress;
c. the expected goals and objectives for the recipient to attain;
d. the details for the method(s) of treatment; and
e. the frequency of treatment sessions, length of each session, and duration of the program.

2. Prior Approval Standards:

a. Prior approval requests will be evaluation for the number, frequency and duration of treatments.
b. The number of services approved will be based on the documented diagnosis, history, and goals.
c. The Utilization Management Unit uses guidelines from the American Occupational Therapy Association and supplemental criteria to evaluate requests for authorization.

3. Prior Approval Criteria:

Prior approval requests for treatment will be reviewed and approved or denied based on the following criteria.

a. Services are for treatment of medically oriented disorders and disabilities.
b. Services are professionally appropriate under standards in the field, utilizing professionally appropriate methods and materials, in a professionally appropriate environment.
c. Services are provided with the expectation that the condition under treatment will improve in a reasonable and predictable time to the identified level.
d. Services are provided with a plan that explicitly states the methods to be used and the termination conditions.
e. Services are requested for a patient suffering from CVA within 90 days of the CVA for adults.

4. Reauthorization:

When reauthorization is necessary after the initial prior-approved sessions, a medical evaluation and documentation from the physician, as well as the therapist, must be attached to the prior authorization request. A new treatment plan is necessary defining the new goals. A new medical summary from the physician must also be attached. An additional request should also include any supplemental data such as past treatment, progress made, family problems that may hinder progress, and a definite termination date. The Utilization Management Unit will review and evaluate requests for continued service requiring reauthorization.

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